Lasting power of attorney: a significant ethical responsibility

A lasting power of attorney makes decisions for another person who lacks the capacity to make the decision him-/herself. There are significant ethical issues which must be considered, not only so that the decision made is morally robust but also so that the individuals entrusted with this responsibility are adequately supported.

The Mental Capacity Act 2005 introduced lasting power of attorney as a way for one individual (the donor) to delegate authority to another (the attorney) to make a decision on his/her behalf. Up to this time enduring power of attorney had provided for attorneys to make decisions about property and financial affairs but the introduction of lasting power of attorneys in the Mental Capacity Act extended the range of issues that donors could authorize the attorney to make decisions about. Lasting power of attorneys can be authorized to make decisions regarding personal welfare, including health care, as well as property and financial concerns.

As with most advance care planning a lasting power of attorney is often seen as a way of extending autonomous decision making so allowing the donor some degree of control over decisions that are made when capacity is lost (Wrigley, 2015). However, decision making for those who have lost capacity is complex and poses significant ethical dilemmas. This article examines some of these difficulties and suggests how best to support those entrusted with this responsibility.

Lasting power of attorney: the facts

In order to create a lasting power of attorney the donor must follow specific procedures as set out by the Mental Capacity Act Code of Practice (Department for Constitutional Affairs, 2007). There are two different forms (available from the Office of the Public Guardian) which may be completed, one for when the lasting power of attorney relates to financial concerns and one for when the lasting power of attorney relates to health and welfare (including, if specified, the ability to consent to or refuse life-sustaining treatment). Completed forms are submitted to the Office of the Public Guardian who will ensure that the forms are completed accurately; any significant error found will result in the forms being returned without the lasting power of attorney having been registered. Perhaps reflecting the degree of responsibility assumed by those appointed as attorneys, the forms are long and detailed. There is, however, a wealth of available guidance available including booklets from the Office of the Public Guardian and beyond (see Leonard, 2013).

As well as the differences between what the two types of lasting power of attorney relate to, there is also a difference in when the lasting power of attorney can take effect. Both types of lasting power of attorney are legally operational once registered (despite the common misconception that a health and welfare lasting power of attorney is only operational once the donor loses capacity) (Leonard, 2013). The difference is that a financial lasting power of attorney can act when the donor still has capacity (unless the donor decides otherwise and specifies this in the form) but a health and welfare lasting power of attorney can only make a decision on the donor's behalf at the point at which the donor lacks capacity to make the decision in question. It is this type of lasting power of attorney that this article will concentrate on. When considering the responsibilities of being a lasting power of attorney it is essential to reflect on capacity, its assessment and about what it means to lack capacity, the concept which sits at the core of the Mental Capacity Act 2005.

Capacity

Capacity refers to the ability to make a decision and plays a central role not only as part of advance care planning and the role of the lasting power of attorney but in all medical care. The assessment of capacity is crucial for an individual; if found not to have capacity then what the individual wants may be taken into account when considering the different options, but the final decision will ultimately be made by another. (If an individual has an advanced decision to refuse treatment this may be seen as a situation where, when capacity is lacking, the individual still makes the final decision. There are, however, numerous ethical concerns around such decisions, see for example Wrigley (2007).) In order to ensure that an individual has every possible chance to be involved in the decision-making process it must be assumed that a person has capacity until it has been clearly shown that he/she does not (Department for Constitutional Affairs,

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2007). The Mental Capacity Act 2005 outlines how capacity should be assessed and in particular how to assess that an individual is unable to make a decision:

A person is unable to make a decision if he/she cannot:

1. Understand information about the decision to be made
2. Retain that information
3. Use or weigh that information as part of the decision-making process
4. Communicate the decision (by any means available) (Department for Constitutional Affairs, 2007).

This stepwise process reflects closely the principles described in several landmark legal cases [Re C (Adult: Refusal of Medical Treatment) 1994; Re MB (Medical Treatment) 1997]. In these cases the capacity to make a decision is explained as the ability to understand and retain information and then to use the information and weigh it in the balance in order to come to a decision (Ward, 2008).

At any one time the decision an individual faces may be relatively simple (for example what to wear) or more complex (for example whether or not to accept a form of medical treatment). An individual who does not have the cognitive function to make a complex decision may still have capacity to make a more simple decision and it is for this reason that capacity is decision specific. This concept of capacity being in relation to specific questions rather than being a blanket state of affairs is fundamental in the Mental Capacity Act 2005.

Making decisions for those who lack capacity

Any individual (or team) faced with making a decision for an individual who lacks capacity must refer to the statutory principles laid out in the Mental Capacity Act 2005 (Department for Constitutional Affairs, 2007). The five statutory principles are:

1. A person must be assumed to have capacity unless it is established that he/she lacks capacity
2. A person is not to be treated as unable to make a decision unless all practicable steps to help him/her to do so have been taken without success
3. A person is not to be treated as unable to make a decision merely because he/she makes an unwise decision
4. Any act done, or decision made for or on behalf of a person who lacks capacity must be done, or made, in his/her best interests
5. Before the act is done or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

Importantly the second statutory principle demands that those assessing capacity must actively try to ensure that everything that can be done has been done to enable the individual to make the decision in question. If, and only if, the individual remains incapable of making a decision with capacity should the decision be made for him/her. (If the individual in question has an advanced decision to refuse treatment which was signed after the lasting power of attorney then the lasting power of attorney cannot consent to treatment refused in the advanced decision; Department of Constitutional Affairs (2007).) For the lasting power of attorney this is likely to be the moment at which he/she becomes the decision maker (as long as the decision falls under the remit of the attorney when registered). An integral part of the Mental Capacity Act 2005 is that when this stage is reached the lasting power of attorney must make a decision based on the best interests of the individual who lacks capacity.

Table 1 gives a summary of what should be considered when making a best interests decision.

For any health-care professional it is important to understand the ethical complexities of making a decision in an individual's 'best interests', not least so that sufficient support can be given to those making the decision.

Ethical considerations

For those in the position of making decisions for those who lack capacity there are significant ethical questions to be addressed. These encompass both the question of the moral authority of such decision makers and whether their decisions can ever be regarded with the same authority as if the decision had been made by an individual with capacity. There is also the matter of how decisions are made for those who lack capacity and it is

Table 1. Considerations when making a best interests decision

Encourage participation by doing whatever is possible to permit and encourage the person to take part in making the decision
Identify all relevant circumstances by trying to identify all the things that the person would take into account if he/she was making the decision or acting for him-/herself
Find out the person's views including past and present wishes, beliefs and values and any other factors the person him-/herself would be likely to consider if he/she was making the decision or acting for him-/herself
Avoid discrimination and do not make assumptions about someone's best interests simply on the basis of his/her age, appearance, condition or behaviour
Assess whether the person might regain capacity and if so whether the decision can be postponed until then
If the decision concerns life-sustaining treatment the person making the decision must not be motivated in any way by a desire to bring about the person's death and must not make assumptions about the person's quality of life
Consult others if it practical and appropriate to do so (including anyone previously named by the individual to be consulted, anyone who cares for the patient, close relatives, any attorney and any deputy appointed by the Court of Protection)
Avoid restricting the person's rights by considering other options which may be less restrictive
Make the decision by weighing up all of these factors

From Department for Constitutional Affairs (2007)

this issue that is concentrated on here. While whole books have been written about making decisions for those who lack capacity this article draws out just a few of the ethical dilemmas in order to illustrate the moral complexity of the process.

Best interests

As seen earlier any decision made by a lasting power of attorney for the donor who lacks capacity must be made in the best interests of the donor. The term 'best interests' is not defined in the Mental Capacity Act 2005 – the reason given for this is that there are too many different types of decisions being made in different situations and for individuals within varying circumstances for one definition to apply (Department for Constitutional Affairs, 2007). What the Act does do, as seen above, is to give a checklist of different issues which must be considered when making a best interests decision. The problem of not having a definition is that it is difficult to know exactly what the decision maker is aiming for or what the goal of the decision making is.

While the Mental Capacity Act 2005 clearly explains that a lasting power of attorney who ensures that the donor does not have capacity and then follows the recommended process to establish what the best interests are should be protected in law, the question remains as to whether the right decision has been made for the individual who lacks capacity. This is a significant burden to place upon the lasting power of attorney and understanding some of the ethical questions helps health-care professionals assist those in the role. Three specific aspects of the best interests guidance which can pose significant issues are now considered.

Past and present wishes and feelings

In making a best interests decision the lasting power of attorney must take into account both the current wishes and feelings of the individual as well as any past wishes and feelings. The difficulty here is that there is no guidance as to how much weight should be given to the past or the present wishes and no suggestion of what to do should the two sets of wishes not sit in agreement. Perhaps the point can most easily be illustrated by considering a patient with dementia. Consider a situation where, while with capacity, the patient comments to the individual appointed to lasting power of attorney that when she has lost capacity she would not want any life-prolonging treatment including antibiotics as she would not want to live any longer than necessary in that condition. Fast forward to a time where the individual now has advanced dementia and does not have the capacity to make the decision regarding antibiotics but has a chest infection. The individual has a productive cough and raised temperature and says that she would like something to help her feel better. In addition she lives life seemingly contented and happy. Without the antibiotics she is likely to die. How much weight does the lasting power of attorney give to the previously expressed wishes and feelings and how much to the current wishes and feelings?

In this scenario the question of why more weight would be given to the previously expressed wishes over the current wishes of the individual must be addressed. Again this largely reverts to the concept of autonomy and respecting autonomy because it is the expression of how an individual wants his/her life to be shaped (Jennings, 2007). Unlike advanced decisions to refuse treatment when a specific decision has been made and ethical debates address whether these decisions hold their moral authority at a time when capacity is lost (also known as precedent autonomy, see Dworkin 1994), in the case of previously expressed wishes and feelings the situation is much less defined or clear cut. Perhaps a helpful approach is to consider what we are trying to balance. Although not the only approach available it is possible to explore the dilemma by considering the theory of experiential interests and critical interests.

Experiential interests are described as things we do because we like doing them, for example cooking or watching sport. The value of these interests lie in the experience that they give, the fact that they are enjoyable. In contrast critical interests are the aims, commitments and hopes that give genuine meaning to life; that give a structured coherence to an individual's story (Dworkin, 1994). It is can be argued that the desire to have this coherence is what, in part, motivates advance care planning. Critical interests are concerned both with how one lives a good life and how value is ascribed to life, and accordingly they are seen as more important than experiential interests (Dworkin, 1994).

Accepting these definitions the individual with advanced dementia still has experiential interests; even those suffering from the most advanced forms of the disease may be able to derive pleasure from a simple touch. However, it is unlikely that those so severely affected will have any sense of their life existing over time and as a consequence of their dementia they cannot act according to their critical interests; they cannot be guided by hopes and commitments which might add value and meaning to life when they cannot comprehend such things. So which should take priority? If we consider that critical interests should dominate then we choose the previously expressed wishes. These wishes are deeply entwined with critical interests because they are an expression of what the individual believes to be the best course of action.

Of course the reality is not that clear cut. It is not obvious that interests can be clearly divided into critical and experiential interests (Dresser, 2006). Consider striving to achieve success at work; while this may be considered a critical interest it also gives a sense of satisfaction and happiness. Although this does not negate the existence of critical and experiential interests it must call into question the validity of the separation and of attributing a

greater significance to critical interests. Interests often change according to situations and experiences. For an individual who develops a life-threatening illness success at work may be of lesser importance while other things assume more importance. For the patient with advanced dementia it is not difficult to see how interests could change and in fact how experiential interests could assume priority.

Quality of life

A second ethical issue which faces a lasting power of attorney who has to make a decision for an individual who has lost capacity to make that decision is that of quality of life. It is widely accepted that any one individual is not in a place to judge the quality of life of another precisely because the only person who can really judge the quality of his/her life is the person in question (Randall and Downie, 1999). Within the Mental Capacity Act 2005 it is very clearly documented that an individual should not make assumptions about the individual's quality of life (Department for Constitutional Affairs, 2007). Different individuals in different circumstances will accept a quality of life which to others may seem poor; similarly an individual may appear to have a reasonable quality of life but actually be suffering such that he/she does not feel that he/she has any quality in his/her existence.

A difficulty presents itself for the lasting power of attorney especially when he/she is making a decision regarding life-prolonging treatment. If the lasting power of attorney is making the decision then the individual at the centre of the decision-making process does not have the capacity to make the decision even though, as seen above, his/her wishes should be considered. However, for the lasting power of attorney it is difficult to decide about potentially life-prolonging treatment without making some judgement about the quality of life of the individual. The decision as to whether to give a certain treatment or choose a certain option depends on how that treatment or option will affect the life of the individual in question (Buchanan and Brock, 1990). It is almost impossible to avoid making a quality of life judgement as often the decisions in question will affect both the length and the nature of the life in question.

The patient at the centre

What is clear about decision making for those who have lost capacity is that they are at the centre of the decision-making process. A best interests decision focuses primarily on the individual in question by considering his/her current and future interests (Buchanan and Brock, 1990). However, in reality there are few, if any, decisions which only affect the individual to whom the decision pertains. Of course the degree to which the attorney's interests are entwined with those of the donor will depend on the relationship between the donor and the attorney. An attorney who is close to the donor will find it more difficult to ignore his/her own interests than an individual who is more detached because he/she personally will have more at stake (Hardwig, 1993). However, it is these attorneys who often know more about the individual and therefore arguably are better placed to be making decisions. Can we really ignore the interests of the attorney completely? Indeed if the donor had capacity to make the decision in question then it is not inconceivable that he/she would be influenced by the interests of others, whether those interests are emotional or more practical.

To some extent the Mental Capacity Act 2005 and guidance reflects this by stating that when making a best interests decision the lasting power of attorney (or other) should 'identify all relevant circumstances' and consider 'any other factors the person themselves would be likely to consider if they were making the decision for themselves' (Department for Constitutional Affairs, 2007). It can be argued that sound moral decisions should take into account the interests of others including family, carers and even society at large (Deveterre, 2000). The difficulty then posed is trying to ensure that the interests of the attorney are not unfairly considered in the decision but also that those interests are not deemed irrelevant (Hardwig, 1993).

An approach to manoeuvring through the ethical quagmire

This article has touched upon three ethical issues which face those appointed as lasting power of attorneys. In reality all advanced care planning raises ethical questions and while these questions (and more) will remain what we need are ways of trying to approach and understand them. To this end an important part of dealing with the ethical dilemmas is to make them known and to discuss them not only with the lasting power of attorney but also with the donor when the lasting power of attorney is appointed. Understanding the difficulties can not only help the lasting power of attorney consider what the right decision is for the patient but also help the patient understand the responsibilities placed on the lasting power of attorney.

Second discussing the ethical issues will ensure that the decision-making process is not seen as merely a 'tick box exercise', that considering the potential problems will lead the lasting power of attorney to think around those issues which are ethically challenging. To support this the lasting power of attorney must, if time allows, discuss the decision not only with those who know the patient (as recommended by the Mental Capacity Act 2005) but also with those who have some understanding of the ethical questions raised in making decisions for those who lack capacity. This may be a health-care professional who can help the lasting power of attorney consider the decision-making process in the context of the patient's current illness and clinical situation. For health and social care professionals an understanding of the ethical difficulties provides an added impetus to support lasting power of

attorneys and, if necessary, a platform from which to challenge a decision (Wrigley, 2015). Finally when making a best interests decision there should be a recognition that in reality 'the best' is impossible to define. What must be achieved is a decision that is reasonable, considered and balanced.

Conclusions

Developed by the Mental Capacity Act 2005 lasting power of attorneys form part of how an individual may plan for a time when he/she lacks capacity. This is often seen as a way for the individual to extend control over the shape of his/her life even when he/she is unable to make capacious decisions. This decision-making process is complex and littered with ethical complexities. Having some appreciation of these difficulties, discussing and acknowledging them gives a foundation on which clinicians can increase understanding of the responsibilities of a lasting power of attorney and ultimately seek to support this person in any decision-making process. BJHM

KEY POINTS

- Introduced in the Mental Capacity Act, two types of lasting power of attorney exist; financial and property attorneys, and health and welfare attorneys.
- Health and welfare attorneys can only make decisions on behalf of the donor when the donor has been found to lack capacity to make the decision in question.
- Capacity is decision specific.
- Any person making a decision for an individual who lacks capacity must make that decision based on the best interests of the individual in question.
- Although the Mental Capacity Act provides stepwise guidance for making a best interests decision there is no definition as to what an individual's best interests are.
- Significant ethical issues are encountered when making a decision for an individual who lacks capacity, including balancing previous wishes against current wishes, assessing quality of life and balancing interests.
- Understanding and discussing even some of these issues will promote acknowledgement of the considerable responsibility that may be placed upon an lasting power of attorney and provide motivation for support of the role.

Conflict of interest: none.

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